

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1947

00482

1055

## CERTIFICATE OF DEATH

Reg. Dist. No.

## 1. PLACE OF DEATH:

County..... Charles

City or town..... Wadons  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

William Henry Atchison

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Lizzie Atchison

7. Birth date of deceased (mo., day, yr.)

Nov. 17, 1871

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

75

1

20

hrs.

min.

8. Birthplace

Somerset, Md.  
(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

Wittie Atchison

12. Name

Somerset, Md.

13. Birthplace

Maeie Pickens

14. Maiden name

Wadons, Md.

15. Birthplace

Lizzie Atchison (Wife)

16. Informant

Wadons, Md.

Address

Burial

(Burial, cremation, or removal, which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Oakland

Location

Wadons, Md.

18. Funeral director

Hunt &amp; Ryan

Address

Wadons, Md.

19. 1-7

(Date rec'd by registrar)

19-47

M. P. Brown

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State..... Md.

County..... Charles

City or town..... Wadons

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2. (a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....

11-4

19

47

M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

4-10

19-46

to 11-4

19-47

and that I last saw him..... alive on.....

19.....

Immediate cause of death.....

Myocardial  
decompensation

DURATION

Due to.....

Cardio-Vas

Due to.....

Renal Dis.

Other conditions.....

Demility

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE.....

Wadons, Md.

M. D. or other

Address.....

Date signed

11-7-47

RECEIVED

JAN 9 1947

BUREAU V S.

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 00483

1. PLACE OF DEATH: *Charles*  
County.....  
City or town.....  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?.....  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State..... County.....  
City or town.....  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.....  
(If rural, give LOCATION)  
2.(a) If veteran, name war.....

3. (a) FULL NAME  
*Nathaniel Green Cruzen*

3. (b) Social Security Number

4. Sex *M* 5. Color or race *W* 6. (a) Single, married, widowed, or divorced *Single*  
6. (b) Name of husband or wife.....  
7. Birth date of deceased (mo., day, yr.) *March 16, 1924* 6. (c) If alive, give age..... years  
8. AGE: Years *22* Months Days less than one day  
hrs. min.

9. Birthplace.....  
(Town, county, and state)  
10. Usual occupation.....  
11. Industry or business.....

FATHER 12. Name *R. H. Cruzen*  
13. Birthplace.....  
MOTHER 14. Maiden name *Elizabeth Engle*  
15. Birthplace.....

16. Informant *Capt. B. H. Haulan*  
Address *Naval Powder Factory*  
*Cremation*  
17. (Burial, cremation, or removal. Which?) Date thereof *Jan 6, 1947*  
(month) (day) (year)  
Cemetery or crematory *Fort Lincoln*  
Location.....

18. Funeral director *W. W. Chamber Co*  
Address *3012 M St N.W. Wash D.C.*  
19. *1/4* *47* *Odey Price*  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... 1-4 at 4 P M  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
and that I last saw h..... alive on.....  
Immediate cause of death.....  
Due to.....  
Other conditions.....  
(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....  
Autopsy results.....  
PHYSICIAN: Please underline the cause to which death should be charged statistically.  
22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide *Accident* Date of *1-4-47*  
Where did injury occur? *Indian Chas* (City or town) (State)  
Injured at home, farm, industry, public place (where)? *Duck blind*  
Means of Injury *Shotgun wound* Injured at work?  
23. SIGNATURE.....  
Address..... Date signed.....

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JAN 10 1967

BUREAU OF

2-35

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

00484

## CERTIFICATE OF DEATH

Reg. Dist. No. 1050

### 1. PLACE OF DEATH

County.....*Charles*  
City or town.....*Wanzenoy*  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?.....*6 1/2 yrs.*  
Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

### 3. (a) FULL NAME

*Sarah Jane Davis*

### 3. (b) Social Security Number

4. Sex.....*F* 5. Color or race.....*W* 6. (a) Single, married, widowed, or divorced.....*Married*  
6. (b) Name of husband or wife.....*Grover Oakland Davis*  
6. (c) If alive, give age.....*61* years  
7. Birth date of deceased (mo., day, yr.).....*Aug 28, 1884*  
8. AGE: Years.....*62* Months.....*4* Days.....*23* hrs..... min.....

9. Birthplace.....*Wanzenoy, Charles Co. Md.*  
(town, county, and state)

10. Usual occupation.....*Housewife*

11. Industry or business.....

12. Name.....*John Scott*

13. Birthplace.....*Charles Co. Md.*

14. Maiden name.....*Marjory Lorrell*

15. Birthplace.....*King George Va.*

16. Informant.....*Oakland Davis*

Address.....*Wanzenoy, Md.*

17. Burial, cremation, or removal, Which?.....*Burial* Date thereof.....*June 32 1947*  
(month) (day) (year)

Cemetery or crematory.....*Baptist*

Location.....*Wanzenoy Md*

18. Funeral director.....*Shift & Ryan*

Address.....*Wanzenoy Md*

19. *1-21* 19 *47* *M. L. Moore*  
(Date rec'd by registrar) Registrar

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State.....*Maryland* County.....*Charles*  
City or town.....*Wanzenoy*  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.....  
(If rural, give LOCATION)  
2. (a) If veteran, name war.....

### MEDICAL CERTIFICATION

20. DATE OF DEATH.....*Jan. 20* 19 *47* at *10:35* P. M.  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *Jan 17 1937* to *Jan 20 1947*  
and that I last saw him alive on *Jan 18 1947*

Immediate cause of death.....*Memoria - Asthenia*

Due to.....*Cerebral Anoxia*

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....*Geo. C. Beckwith*

Address.....*Jan 20 1947*

Date signed.....

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

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JAN 22 1947  
BUREAU

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

00485

Reg. Dist. No. 1312

## 1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (a) FULL NAME

## 3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal, which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19.

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

19.

at

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

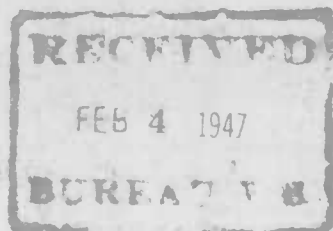
Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed



1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

93a

00486

Reg. Dist. No. 101

## 1. PLACE OF DEATH:

County..... Charles  
 City or town..... Pisgah  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 30 years  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State..... MD. County..... Charles  
 City or town..... Pisgah  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Caroline Swann

## 3. (b) Social Security Number

4. Sex..... Female 5. Color or race..... Colored 6. (a) Single, married, widowed, or divorced..... Widowed  
 6. (b) Name of husband or wife..... James A. Swann  
 6. (c) If alive, give age..... years  
 7. Birth date of deceased (mo., day, yr.)..... June 16, 1867  
 8. AGE: Years..... 79 Months..... 6 Days..... 21 If less than one day..... hrs..... min.  
 9. Birthplace..... Charles County, MD.  
 (Town, county, and state)  
 10. Usual occupation..... Housewife  
 11. Industry or business..... own Home  
 12. Name..... Not Known  
 13. Birthplace.....  
 14. Maiden name..... Not Known  
 15. Birthplace.....

MOTHER FATHER

16. Informant..... Carroll N. Swann  
 Address..... Pisgah, MD  
 17. Burial..... Burial Date thereof..... Jan 10, 1947  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory..... St. Charles Catholic  
 Location..... Glymont, MD  
 18. Funeral director..... Perry & Cofer  
 Address..... Mason Springs, MD  
 19. 1/8..... 19..... 47 Mary Swannland  
 (Date rec'd by registrar) (year) (month) (day) (year) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... January 7, 1947 at..... 9:30 A. M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... 19..... to..... 19.....  
 and that I last saw him..... alive on..... 19.....

Immediate cause of death..... Acute Myocarditis

DURATION

Due to.....  
 Due to.....  
 Other conditions.....

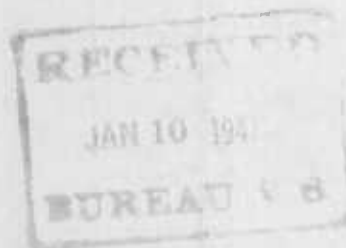
(Include pregnancy within 8 months of death)

Major findings of operations..... Date of op.....

Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur?..... (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury..... Injured at work?

23. SIGNATURE..... Public Health Officer M. D. or other  
 Address..... Indian Head, MD Date signed..... 1/7/47



1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 101

## 1. PLACE OF DEATH:

County.....Charles  
 City or town.....Harbury  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?.....38 years  
 Hospital, institution, or street address where death occurred:  
 \_\_\_\_\_  
 How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....md County.....Charles  
 City or town.....Harbury  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Frank FRANK Thomas

## 3. (b) Social Security Number

4. Sex.....Male 5. Color or race.....Colored 6.(a) Single, married, widowed, or divorced.....Married  
 6.(b) Name of husband or wife.....Minnie  
 6.(c) If alive, give age.....55 years  
 7. Birth date of deceased (mo., day, yr.).....Dec. 15, 1882  
 8. AGE: Years.....64 Months.....0 Days.....28 If less than one day..... hrs. .... min.

9. Birthplace.....Charles County  
 (Town, county, and state)  
 10. Usual occupation.....Water Attendant  
 11. Industry or business.....U.S.N.P.F. Indian Head  
 12. Name.....Frank Thomas  
 13. Birthplace.....Charles Co. Md  
 14. Maiden name.....Julia Posey  
 15. Birthplace.....Charles Co. Md.

16. Informant.....Mrs Lloyd Thomas  
 Address.....Harbury Md.

17. Burial.....Burial Date thereof.....Jan. 22, 1947  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....mt Hope  
 Location.....Worcester, Md  
 18. Funeral director.....L. B. Montomery

Address.....913 Florida N.W. Wash. D.C.

19. Jan 17 1947 may & atty  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....January 17, 1947 at 5:10 P.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 2 1947 to Jan 17 1947  
 and that I last saw him alive on Jan. 16 1947

Immediate cause of death.....Myocarditis  
 DURATION.....1 yr.

Due to.....  
 Due to.....

Other conditions.....Hypertension  
 (Include pregnancy within 8 months of death)  
 DURATION.....3 yrs

Major findings of operations.....  
 Date of op.....

Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....  
 Means of injury..... Injured at work?.....

23. SIGNATURE.....Frank L. H. Susan L. S.  
 Address.....Indian Head Md M. D. or other.....  
 Date signed.....1/17/47

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JAN 29 1947  
BUREAU

2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 1000

## 1. PLACE OF DEATH:

County CharlesCity or town La Plata  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 1/2 hr.Hospital, institution, or street address where death occurred: Physician Memorial HospiceHow long in hospital or institution? 1/2 hr.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County CharlesCity or town Potomac Heights, Md.  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Turnage

## 3. (b) Social Security Number

4. Sex

male

5. Color or race

white

6.(a) Single, married, widowed, or divorced

single

6.(b) Name of husband or wife \_\_\_\_\_

6.(c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) January 28, 19478. AGE: Years Months Days It less than one day  
0 0 0 30 hrs. min.9. Birthplace La Plata, Charles, Md.  
(Town, county, and state)10. Usual occupation Infant

11. Industry or business \_\_\_\_\_

12. Name Carl Nelson Turnage13. Birthplace South Carolina14. Maiden name Ethel Wedding15. Birthplace Welcome, Maryland16. Informant Carl TurnageAddress Potomac Heights, Md.17. Burial Date thereof Jan 28, 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Memorial Baptist ChurchLocation Memorial, Md.18. Funeral director Carl TurnageAddress Potomac Heights, Md.19. 1-28 19 47 Julius H. Perry  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 28 19 47 at 7:10 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

on Jan. 28 19 47 to Jan. 28 19 47and that I last saw him alive on Jan. 28 19 47

Immediate cause of death \_\_\_\_\_

DURATION 35-40'Cerebral hemorrhageDue to Birth accidentDue to Proximate breech delivery

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Janet MacKinnon, M.D.  
M. D. or otherAddress La Plata, Md. Date signed 1-28-47

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JAN 31 1947  
BUREAU

1-35